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LOYOLA UNIVERSITY CHICAGO

A STUDY TO DETERMINE THE
EFFECTS OF CLIENT PARTICIPATION IN CARE
ON PERCEIVED CONTROL/POWERLESSNESS AND MORALE

A THESIS SUBMITTED TO
THE FACULTY OF THE SCHOOL OF NURSING
IN CANDIDACY FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

DEPARTMENT OF NURSING

BY

JANIS MARIE ORMOND

CHICAGO, ILLINOIS

MAY 1993

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CHAPTER I

INTRODUCTION

As a society we strive to ensure the health and happiness of all individuals. The physical and psychological health of our citizens is of particular importance to those who deliver health care services. As the percentage of elderly people increases, health care workers must pay specific attention to the needs of this rapidly growing segment of the population. Ensuring a happy and productive old age for those individuals who must enter a long-term care facility is essential. Thus, it is important to identify ways to improve the delivery of care in institutional settings. The physical aspects of care are usually the first to be focused upon; however, the psychological factors may be equally important because they may play an important role in the client's motivation to continue striving for a healthy life. One very important psychological factor is the ability to maintain independent living. As life situations change with age, the older adult experiences some loss of roles, health, and support systems which increases the risk of losing personal control. Entry into a long term care facility as a result of declining health may also threaten the ability of clients to maintain personal control. Johnson (1967) states that, low control

over one's fate, reliance upon experts, bureaucratic authority, and the loss of support systems are recurrent elements that clients experience, to some degree, when they enter a health care facility (Johnson, 1967).

Schulz and Aderman (1973) have noted that a patient's adverse reactions to institutionalization are probably mediated by feelings of helplessness. These feelings of helplessness are born out of the patient's perception that the institutional demands for passivity represent a real loss in his ability to control the environment.

Feelings of loss of personal control can lead to low self-esteem, depression, hopelessness, isolation, loneliness, and eventually death (Miller, 1983). Therefore, it is important for health care workers to provide care which allows patients to perceive that they have personal control.

The 1990 Omnibus Budget Reconciliation Act (OBRA) mandates changes in delivery of care to ensure resident rights and quality of care. OBRA regulation F171 and F172 state that:

The resident has the right to be fully informed in advance about care and treatment and of treatment that may affect the residents well being; and unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or

changes in care and treatment.

The interpretive guideline set forth by OBRA {483.10 (d) (1)-(3)} states that: "Informed in advance means that the facility discusses with the resident or his/her legal representative treatment options and alternatives and the resident selects and approves of the specific plan of care before it is instituted."

Although it is believed that residents of long term care facilities will benefit from greater involvement in their care and the 1990 OBRA regulations mandate this involvement in care, there is little research to support this hypothesis. Studies to determine the benefit of increasing resident rights and participation in care are needed to validate these new OBRA regulations.

Statement of Purpose

The purpose of this study was to determine the effects of the institutionalized older adult's ability to control his/her own plan of care (through planning, implementation, and evaluation) on his/her perceived control and level of morale. Previous research has shown that perceived control does affect morale; therefore, providing patient control over the plan of care may result in clients who perceive themselves as more in control and consequently experiencing higher morale.

Conceptual Framework

A review of the literature provided the basis for the conceptual framework used in this study (see figure 1: conceptual framework). The model consists of three main variables. It was hypothesized that a client's influence over care impacts feelings of perceived control and morale. As perceived control increases, so too does morale. The additional variables of locus of control, institutionalization, aging, level of wellness, and level of knowledge can also affect a client's feelings of perceived control. Level of knowledge can affect both client participation in care and feelings of perceived control.

Relevant Variables

Concepts Defined

1. Institutionalized older adult: A person 60 to 85 years of age at his last birthday at the time of the interview who is presently residing in the long-term care facility.
2. Client involvement in planning and implementing care: A plan of care which is developed by both the nurse and client. The client should be active in all of the stages; assessment, planning, intervention, and evaluation. The plan of care is implemented by the client and staff working collaboratively.
3. Powerlessness: A client-validated feeling of loss or lack of control of self-care, situations, and/or health

within a given circumstance. Feelings of powerlessness are derived from the clients perceived control over specific events.

4. Perceived control: A client validated feeling of control of self-care, situations, and/or health status within a given circumstance.

5. Morale: An inner state of an individual in which he/she feels a sense of satisfaction with self, has a feeling of fitting in with the environment, strives for positive aspects of living, but accepts what cannot be changed.

6. Locus of control: Locus of control refers to an attitude or perception, that is relatively unchanging, about an individual's ability to control situations or events. It refers to the generalized expectancy of control (Rotter, 1966).

a) Internal locus of control: An internal control person perceives events as consequences of their own actions and under their own control.

b) External locus of control: Externally controlled individuals generally perceive events as beyond their own control, as resulting from either powerful others or chance.

7. Level of knowledge: The degree to which the client understands his health care needs. This includes understanding of the disease process, treatment

alternatives, and expected outcomes related to the interventions taken.

8. Level of wellness: Every aged person has an attainable optimal level of wellness. Wellness is more than an absence of illness. It involves one's whole being striving to be in balance. There are five dimensions of wellness: self-responsibility, nutritional awareness, physical fitness, stress management, and environmental sensitivity (Ebersole & Hess, 1985).

9. Support systems: All persons, groups, or animals that contribute to meeting the interdependence needs of the person. Interdependence is the close relationships of people that involve the willingness and ability to love, respect, and value others, and to accept and respond to love, respect, and value given by others. See Figure 1 in Appendix A for the conceptual framework which shows the relationship among these variables.

Operationalization of Concepts

1. Participation in the plan of care: Staff interviews and auditing of patient care records were used to identify the amount of participation in planning, implementation, and evaluation of care by each patient.

2. Perceived control: The perception held by individuals that they are involved in and responsible for the planning, implementation, and evaluation of their own care as measured by The Nurse-Patient Interaction Tool (see

Appendix B for tool).

3. Powerlessness: The perception held by an individual that they are not involved in and responsible for the planning, implementation, and evaluation of their own care was measured by The Nurse-Patient Interaction Tool (see Appendix B for tool).

4. Morale: A verbalized feeling of self-satisfaction, belonging, and striving for positive aspects of living while accepting those things that cannot be changed. These were measured by the PGC Morale Scale (see Appendix C for tool).

Hypotheses

The following hypotheses were tested.

Hypothesis I: Older institutionalized adults who are able to influence the planning and implementation of their care will have less perceived feelings of powerlessness than those who do not have direct involvement in planning and implementing their care. Hypothesis II: Older institutionalized adults who are able to influence the planning and implementation of their care will have greater morale than those who do not have direct involvement in planning and implementing their care.

CHAPTER II

REVIEW OF THE RELATED LITERATURE

This literature review is organized according to the conceptual framework developed for this study. Refer to Figure 1 in Appendix A for an overall visual view of the relationships among the concepts.

Effects of Client Influence Over Care on Perceived Control and Morale

Traditionally, the relationship between the patient and the provider has been one of unequal power; care is planned by the provider for the client (Parsons, 1975; Scheff, 1963). The formation of an interdependent relationship between health care professionals and clients is now being advocated (Grieco, Garnett, Glassman, Valoon, McClure, 1990; Krouse, Roberts, Michaud, 1990; Lenrow & Burch, 1981). Developing models of self-care and increased client involvement have been of great importance to nurses (Orem, 1985; Roy, 1984).

In a study with a sample of 106 patients in a psychiatric clinic, Eisenthal and Lazare (1976) found that patients placed a high priority on feeling in control of their fate during an interaction. Krouse and Roberts (1989), in a study of 84 undergraduate nursing students,

found that those who participated in an actively negotiated process of decision making with a practitioner perceived more control over their care and had fewer feelings of powerlessness. In a second study of 98 ambulatory patients with upper respiratory symptoms, Krouse et al. (1990) found that patients who participated in an actively negotiated style expressed significantly greater feelings of control during the interaction with the nurse.

Folkman and Lazarus (1988) found that planful [sic] problem-solving was associated with more positive emotion and less negative emotion.

Kreidler and Campbell (1989) explored the applicability of a wellness model to nursing interactions with community based elderly. The wellness model promotes self-healing, self-care, and self-responsibility in a partnership with health care providers. They found that clients in this program exhibited a holistic perspective of the mind and body interaction. This holistic perspective has been defined by Ardell as wellness: a search for paths and experiences that enable the elderly to be all they can be in ways that are personally perceived as important (cited in Kreidler & Campbell, 1989).

Montbriand and Laing (1991) studied patient's use of alternative health care as a control strategy. In an ethnographic study of 75 patients they found that the subjects resorted to choosing alternative health care in a

covert manner, while still appearing compliant, to seek ways to gain their own control of events. This study indicates that patients view themselves as in control, despite efforts by medical personnel to control the patient's plan of care.

Relationship Between Perceived Control and Morale

Otto and Featherman (1975) assert that alienation is a perceived discordance between the real and the ideal. They divide alienation into two forms: powerlessness and self-estrangement. Powerlessness relates to the individual's expectancy concerning the occurrence of the outcomes one seeks. Self-estrangement refers to an individual's lack of intrinsic satisfaction. Powerlessness and self-estrangement are not viewed as reflections of a common construct but as two kinds of alienation differentiated by the values that they imply. Research by Otto and Featherman (1975) indicates that covariation between powerlessness and self-estrangement has its source in common antecedents: socioeconomic status, family background, and mental ability.

In a study of 1,645 adults in a Southeastern county, Schwab (1976) found that feelings of powerlessness were the major diagnostic indicators of depression in the elderly. Other symptoms such as lowered spirits, feeling helpless, and problems with sleep and appetite also were diagnostic of depression in the elderly.

In a quasi-experimental study, Schulz (1976)

studied the effect of increased predictability and control on physical and psychologic well-being of 40 elderly subjects living in a retirement home. Subjects who were able to predict but not control when they would receive a visitor and subjects who were able to control when they would receive a visitor had significantly higher hope levels, less time lonely, less time bored, greater zest for life, and greater happiness, usefulness, and a higher activity level than subjects in the no-treatment group.

Schulz and Hanusa (1978) did a follow-up study on these same subjects. Data were collected 24, 30, and 42 months after the 1976 study. No positive long-term effects attributable to the interventions were found. These results indicate that the intervention needs to be maintained to provide continued effects.

Langer and Rodin (1976) looked at the effects of enhanced personal responsibility and choice on alertness, activity participation, and overall sense of well-being. Subjects in the responsibility-induced group were significantly more active, alert, happy, and generally improved. No significant difference was found on the perceived-control measure between the two treatment groups.

In a follow-up study, Rodin and Langer (1977) reported that those subjects in the control-induced group had sustained beneficial effects. Mortality rates showed a striking difference in that only 15 percent of the subjects

in the responsibility-induced group had died during the 18 months, whereas 30 percent of the comparison group died.

Chang (1978) found that of 30 nursing home residents studied, those who perceived themselves in control of their immediate situations as determined by the Situational Control of Daily Activities scale had higher morale scores regardless of their internal or external personality orientations. Although Chang's study did show a relationship between situational control and morale, the scale did not measure the client's perceived control; rather, it measured who performed each of the activities of daily living for the client.

Davidson and O'Connor (1990) examined the effects of perceived control over the decision to enter a nursing home as determinants of changes in functional health and morale. Study results indicated that subjects who perceived themselves in control had better outcomes in the first month. However, between the second and fourth month these same individuals showed negative effects on health and morale. Subjects in this study were relocated into "high constraint" environments. Thus, although interventions that attempt to increase perceived control over admission decisions may have short-term benefits they have long-term negative consequences if they are not matched by ongoing efforts to increase control opportunities in daily nursing-home life.

The Relationship Among Social Support, Morale, and Powerlessness

Schwab (1976) states that only an adequate social support system will ameliorate the distress of the aged. He recommends a humane and personal system to assist the elderly.

Research by Otto and Featherman (1975) indicates that adult social integration lowers one's sense of powerlessness. However, they also found that social participation and socializing had no total and direct effects of intrinsic satisfaction.

The Relationship Between Level of Knowledge and Perceived Control

Martin, Holt, and Hicks (1981) assert that people communicate best when they speak the same language. Thus, it is the nurse's responsibility to help facilitate learning and remove barriers to learning. If clients sense the importance of their input and perceive they have power in decision making, they will be better able to express their concerns, identify their problems, and work toward solutions.

Ebersole and Hess (1985) agree that the aged, given sufficient knowledge about their condition, can and should be involved in decision making about alternatives that will affect them. Patients do seek information and knowledge

which enhances their sense of control by increasing involvement in the care regimen.

In an analysis of several case studies, Mahon-Darby, Ketchik-Renshaw, Richmond, and Gates (1988) found that feelings of power increase as the nurse provides means to achieve an adequate knowledge base with which the patient can learn to direct his care. Providing information helps the patient to anticipate what will happen next which enhances perceived control.

In a study of 45 older, male, diabetic patients, Gilden, Hendryx, Casia, and Singh (1989) found that diabetes education programs improve older patients' perceived ability to manage and cope with their disease. They also found that family involvement maximizes the beneficial effects of educational interventions.

The Relationship Among Aging, Level of Wellness, and Powerlessness

The concept of wellness goes beyond the physical definition of health. Wellness is an attitude, an ongoing process, and involves one's whole being--physical, emotional, mental, and spiritual. Even in chronic illness and dying there is an optimal level of wellness attainable for each individual. Although, as a group, the aged do suffer from chronic conditions which lead to physical

deterioration, they still can maintain control over their lives and achieve a self-defined level of satisfactory existence: the attainment of well-being (Ebersole & Hess, 1985).

Self-responsibility is a major component of the maintenance of wellness. The elderly of today are making great strides in controlling their own lives. New options which allow the elderly to stay in control are needed. Nurses can enhance and support the aged individual's movement toward self-responsibility by exploring with the aged the underlying situations that may be creating a wellness imbalance and discussing the alternatives available. Given sufficient unbiased information, in most instances the aged can make meaningful decisions (Ebersole & Hess, 1985).

Chronic conditions which diminish an individual's ability to care for oneself have a significant impact on perceived feelings of powerlessness. In an analysis of research that was done with acute spinal cord injury patients, Sullivan (1990) found that patients who are facing severe functional disability may also experience a sense of powerlessness.

The Relationship Between Institutionalization and Powerlessness

Loos and Julius (1989) completed a qualitative study using descriptive exploratory methods. Their purpose was to

explore the feelings that pregnant clients had during hospitalization. The results indicated that loneliness, boredom, and powerlessness were the three most prevalent feelings.

Similarly, Kritek (1981), recorded and analyzed her own feelings during a hospitalization. This exploratory study demonstrated that subjective experiences of patient powerlessness evolved from the health care system's control of time, scheduling, environmental stimuli, and information, as well as the patient's alterations of self-concept and roles.

The Relationship Between Locus of Control and Powerlessness

Locus of control is directly related to powerlessness but differs in terms of frequency of the behavior. Whereas locus of control implies a long-term stable view of why events take place, powerlessness describes the feeling state of a situationally determined event.

Research by Petrosky and Birkimer (1991) suggests that both general and situational perceptions of control are associated with direct coping behaviors.

In a study by Chang (1978), those older adults who perceived themselves in control of their immediate situations, as determined by the Situational Control of Daily Activities scale, had higher morale scores regardless of their internal or external personality orientations.

CHAPTER III

METHODS AND MATERIALS

Selected Design

A quasi-experimental, small sample design was used to examine the causal relationship between client influence over care and the client's feelings of control and morale. More specifically, the design used was the small sample A-B design (Woods & Catanzaro, 1988). The A-B design uses the subject's baseline as a control condition and then, in sequence, introduces the experimental condition. The A stands for the baseline condition before the independent variable is introduced. The B represents the equivalent period of time after introduction of the independent variable. This design is appropriate for a study that examines causal relationships, manipulates the independent variable (client influence over care), and incorporates a baseline control followed by an intervention period to compare effects. Since in the time frame of this study it was difficult to find enough subjects to provide a large randomized sample, a quasi-experimental small sample design, rather than an experimental design, was used.

Design Strengths and Limitations

This design's major strength is its usefulness for

testing causal hypotheses in field settings. In addition, because the subjects are studied in their natural environment, the findings are more likely to be representative of the real world and thus more generalizable than true experimental findings (Brink & Wood, 1989).

A major limitation with the small group A-B design is the distinguishing of the main effects from extraneous variable effects. The lack of the ability to randomize generally results in nonequivalent groups. To control for this, pretests are essential in quasi-experimental designs (Cook & Campbell, 1979). In addition, it is essential to actively analyze and attempt to rule out other causal explanations for the findings before concluding that the treatment variable produced the differences in the outcome variables (Brink & Wood, 1989).

The A-B design of multiple pretests, intervention, and multiple posttests helps to establish a clear picture of trends to determine causal effects from the independent variable rather than extraneous variables. The small sample design was used due to an anticipated limitation of subjects and resources. However, the ability to generalize, when using the small sample design, is extremely limited. Replication of the study with larger samples will need to be done in the future.

Threats to Validity and Methods to Control Threats

Cook and Campbell (1979) identify twelve sources of

extraneous variance that can confound the effects of the treatment on the outcome variable. These are: 1) history, 2) maturation, 3) testing, 4) instrumentation, 5) statistical regression, 6) selection, 7) experimental mortality, 8) selection maturation interaction, 9) selection-history interaction, 10) diffusion or imitation of treatments, 11) compensatory equalization of treatments, and 12) compensatory rivalry by respondents receiving less desirable treatments. Identification and control of these must be built into a quasi-experimental design. The basic design using a control group controls for all but four threats to internal validity. The uncontrolled threats include a) selection-maturation, b) instrumentation, c) differential statistical regression, and d) selection-history. By using a small sample A-B design with pretest and posttest measures at multiple time intervals the subjects provide their own control which also reduces these threats to validity.

Threats to Internal Validity

Selection-maturation. To control for selection-maturation pretesting at multiple time points was used to allow the researcher to determine whether the subjects were growing apart (maturing) between observation one and observation two, independent of the treatments effect on the outcome variables (Brink & Wood, 1989).

Instrumentation. The threat to instrumentation is not

controlled for by pretesting more than once. Control is attempted by looking for floor or ceiling effects as well as scores that are skewed (Brink & Wood, 1989).

Differential statistical regression. Statistical regression can occur when subjects score uncharacteristically high or low on a first test due to error factors that do not reflect true ability, while on subsequent testings their results tend to regress to the mean of the population. If these errors in measurement are present, the individuals who received extreme scores on an instrument at a first measurement are likely to receive scores closer to the population mean on that instrument at the second assessment. Thus, by using multiple pretests the researcher can determine if each observation is inexplicably high or low when compared to observations preceding it (Cook & Campbell, 1979).

History. The threat to history may occur despite multiple pretests. An event, such as a change in operating procedures, may occur between the last pretest observation and the posttest observation in one subject but not the others. Thus, the researcher must closely examine the context of the specific research setting to determine if there were any threats of this nature (Cook & Campbell, 1979).

Testing. This is a threat when the same instrument is used multiple times. Subjects may become more familiar with

the instrument items which may enhance their performance. To control for this, there should be an adequate time frame between administration of repeated tests.

Selection. This is a threat when an effect may be due to the difference between the kinds of people in one experimental group as opposed to another. Because the multiple pretests provided for control, a separate control group was not used. Thus, selection was not a threat in this study.

Mortality. The threat to mortality was a significant threat to this study due to the small sample size. Relatively healthy subjects (for example: those who have not been acutely ill within the past six months) were selected to decrease this threat.

Diffusion or imitation of treatment. This is a threat when subjects are in close proximity to each other and can share information regarding the experiment. This was not be a threat to this study because the subjects provided their own control during the pretesting phase.

Compensatory equalization of treatments. This becomes a threat when the experimental treatment is believed to be desirable. Administrative and constituency reluctance to tolerate the inequality between treatments results. Although there is a small risk of nurses equalizing pre- and post-intervention treatments, if nurses are properly informed of the nature of this study they will be less

likely to equalize treatments. Staff and administration must fully support this project to control for this problem.

Threats to External Validity

This study will have very limited generalizability due to the absence of random sampling and the small subject group. By using the impressionistic modal instance model, external validity can be increased. In this model the researcher must explicate the kinds of persons, settings, or times to which one most wants to generalize and then select subjects which are impressionistically similar to the class mode (Cook & Campbell, 1979). This model limits generalizability to the sub-population of individuals who share the characteristics of the subject groups.

Construct Validity

Construct validity is defined as how well a construct fits with the instrument used to measure it. It involves attempting to validate a body of theory underlying the measure and testing hypothesized relationships. Since the study focused on the client's perceived feelings of power or powerlessness, an instrument that measures the clients perception of control was used.

Explication of concepts and how they are operationalized further reduces the threat to construct validity. In addition, the researcher analyzed data objectively to avoid experimenter bias of the data resulting

from experimenter expectancy.

Statistical Conclusion Validity

Statistical conclusion validity is defined as determining if the study is sensitive enough to permit reasonable statements about covariation. It is concerned with drawing false conclusions about population covariation from unstable sample data. The threat of low statistical power (how much power one has to detect an effect of a given magnitude with the variances and sample sizes on hand) was a consideration in this study because of the small sample size.

Instruments with reliability greater than .70 were used to help decrease the threat of measure reliability. Random irrelevancies in the experimental setting were controlled for by choosing subjects and settings with the least extraneous sources of variation and by controlling for the extraneous variables. By choosing subjects who are homogeneous, the threat of random heterogeneity of respondents was decreased. However, this reduces external validity which has already been identified as a limitation of this study.

Another major threat to this study was the reliability of treatment implementation (the amount of participation in planning care). This causes inflation of error variance and decreases the chance of obtaining true differences. Standardizing treatment implementation and documenting that

implementation for future analysis helped to determine error variances. The amount of participation in care planning was operationalized by reviewing input from clients, staff, and care plan records.

Sample Size and Selection

A small sample design was chosen due to a limitation of subjects and resources. The experimental group had five subjects. The subjects were purposefully selected to meet the criteria. All subjects were between the ages of 60 and 85. They were cognitively intact, had sufficient energy to participate in testing, and were able to understand and read English. Subjects were randomly selected from a pool of purposefully selected cognitively alert residents. Since studies have shown that the best determination of cognitive ability is to have the nurses give a list of those residents who are alert and generally oriented, this method was employed.

All subjects were institutionalized for at least one month and no longer than two years. To control for the influence of level of wellness, all subjects were free from acute illness but had some limitation related to a chronic illness (this provided homogeneity of subjects).

A small sample design was appropriate because the subjects could be followed over time for multiple pretests and posttests. The timing of implementing the intervention was under the control of the researcher rather than being

controlled by natural circumstances; therefore, adequate time for pretesting was available.

The A-B (A=baseline and B=intervention period) rather than the A-B-A (in this design the baseline is returned to for an equal time period) design was used because the intervention effects were relatively long acting. The purpose of this study was to look at a causal relationship between the variables; therefore, the A-B design was used to control for internal validity. By holding the extraneous variables constant and achieving a stable and long baseline set of measures before introducing the independent variable, the small sample design controls for the threats to internal validity (Woods & Catanzaro, 1988).

Data Collection

Data were collected using several questionnaires. In addition, the nurse wrote a care plan with documentation of the client's level of involvement. Clients and nursing staff were interviewed by the researcher on a routine basis to determine the level of client involvement and insure proper implementation of the treatment. Data were collected during day time hours to ensure peak cognitive performance.

Instruments

The dependent variable 1.) control versus powerlessness was measured by using the Nurse-Patient Interaction Tool. The original Nurse-Patient Interaction Tool is a four-point

Likert-type scale with 44 questions. The areas assessed include patients' perceptions of satisfaction, ability to comply with care, feelings of control and power, and degree of participation in the interaction and treatment decision.

Preliminary testing of the Nurse-Patient Interaction Tool was conducted with a sample of 84 undergraduate nursing students. Initial analyses of responses to this tool indicated an overall internal consistency (Cronbach's alpha) of 0.76. The factor of control vs powerlessness had a Cronbach's alpha of 0.93 and the factor of agreement with diagnosis and treatment choice had a Cronbach's alpha of 0.90. This tool provided interval data. Only the questions related to perceived control and satisfaction were used for this study. The tool was composed of 14 questions.

The second dependent variable 2.) morale, was measured by the Revised Philadelphia Geriatric Center (PGC) scale (Lawton, 1975) and the Nurse-Patient Interaction Tool (Krouse & Roberts, 1990). The latter tool is explained above. The PGC scale consists of 17 dichotomous items that measure an individual's inner state of satisfaction; life attainment, fitting in to the environment, and the ability to strive appropriately while accepting the inevitable.

In his early work Lawton identified six separate (but related) subcomponents or scales of morale. Two of the components had acceptable levels of reliability as well as a moderate level of validity for the battery as a whole. In

his later work (1975) Lawton revealed that there are only three stable and replicable factors: a) agitation, b) attitude toward's one's own aging, and c) lonely-dissatisfaction. Only 17 of the original 22 questions were retained in the revised instrument (Liang & Bollen, 1983). Using two samples of elderly individuals, Lawton tested the reliability of each of the three factors. The first factor, attitude toward's one's own aging, had reliabilities of .565 and .563. Although these reliabilities are low, they are not factors explored in this study. The second factor, agitation, had reliabilities of .702 and .717. The third factor, lonely-dissatisfaction, had reliabilities of .721 and .740.

Morris and Sherwood (1975) also factor analyzed the PGC Morale Scale. They reproduced three factors similar to Lawton's but their final solution consisted of 15 items which loaded on two factors.

To measure the effects of the extraneous variable Locus of Control, Rotter's Internal-External Locus of Control Scale (Rotter, 1966) was used as a one time measurement when the subjects entered the study (See Appendix D). This scale measures the extent to which individuals hold expectancies that events in their lives are contingent on the behavior of self, powerful others, or chance. Rotter's definition of the construct deals only with a person's perception of his behavior and events which follow that behavior.

In factor analyses done by Rotter and others the results revealed one general factor which accounted for much of the total scale variance. The one factor has to do with one's belief in his own control. An internal consistency coefficient of .70 was obtained from a sample of 400 college students. Rotter's sample test-retest reliability coefficients were computed, with a value of .72 for 60 college students.

The instrument consists of 23 question pairs, using a forced-choice format, plus six filler questions. Internal statements are paired with external statements. One point is given for each external statement selected. Scores can range from zero (the most internal) to 23 (the most external).

Study Process and Procedure

To clarify the actual process of this study a time line is included (see Appendix E, Figure 2: Process and Procedure: A Time Line). The process of subject identification, authorization from the long term care facility, and education of administration and staff regarding the study was accomplished before the study began. Once five subjects had consented to inclusion in the study, baseline data were collected. Each of the three tools were administered by the researcher in an interview structure. The interview method was selected, rather than the

independent completion of each questionnaire, to ensure complete understanding of the questions and to avoid difficulties with vision or formatting.

The locus of control tool was administered one time at the start of the study to assist in identifying correlations between locus of control and powerlessness. The Nurse-Patient Interaction Tool and the PGC Morale Scale were also administered when the study began. This provided the start of baseline data. The Nurse-Patient Interaction Tool was then administered two more times to complete the baseline data collection. The three baseline data collections were separated by 21 days. Following the third data collection the client was assisted by the nurse to become more involved in planning and implementing his/her own care. The Nurse-Patient Interaction Tool was again administered 21 days following the beginning of the intervention and then again in another 21 days. At the conclusion of the study the Nurse-Patient Interaction Tool and the PGC Morale Scale were again administered. The outcome provided three baseline data collections separated by 21 days each, an intervention, and three post intervention data collections again separated by 21 days each.

At each data collection the client's level of involvement in care was assessed by both the nursing staff and the client. The degree of involvement ranged from no involvement to a large degree of involvement and was

determined based on documentation as well as input from staff and clients.

Statistical Methods

According to Woods and Catanzaro (1988), small sample research began by capitalizing on strategies to show large effects and thus did not rely on statistical analysis. Rather, they believe that if one has a long stable baseline and if the intervention has an effect, one should clearly see it in graphic display. Thus, a graphic display was used for this study. According to Woods and Catanzaro (1988), visual description of graphs of the data is adequate for inference of experimental effect.

Ethical Considerations

First, permission from the administration to enter the facility was attained. Subjects were given information to allow them to make informed consents. The nature of the study, procedures to be used, nature and amount of risk or discomfort, anticipated benefits, assurance of confidentiality, and opportunity to ask questions were presented to each subject. Signed consent forms were then obtained. The researcher chose subjects who were able to comprehend the above information. Subjects that met the required criteria were then asked to participate.

In a study done by Schulz and Hanusa (1978), the long-term effects of participating in a field experiment were

reported. The authors found some evidence to support the idea that removing a client's ability to control his environment, after it has been instituted for a study, can have negative long-term effects. Several strategies to avoid this were presented. Debriefing the subjects at the conclusion of the study, preparing subjects for closure of the study by informing them that the interventions will end when the study ends, and providing a means to continue the interventions after the study has ended are methods to avoid negative consequences related to the study.

The subjects were informed that continuation of the study conditions could not be guaranteed. However, they were given assurance that influence would be used to ensure continuance of the study process if possible.

CHAPTER IV

FINDINGS

Selected Sample

Data were collected from subjects who resided in a 200 bed nursing care facility. Fifteen elderly adults between the ages of 60 and 85 were purposefully selected based upon the criteria of cognitive intactness, sufficient energy to complete the study, nursing recommendation, and ability to understand and read English. Five subjects were then randomly selected from the original fifteen.

Each of the subjects had resided in the facility for more than one month and less than one year. The sample consisted of four caucasian females and one caucasian male. The subjects were informed of the nature of the study, potential risks and benefits, and assurance of confidentiality. Written permission was then obtained.

Results

A small sample A-B design was used to examine the causal relationship between client influence over care and the client's feelings of control and morale. During the A or control phase, an interview process was used to collect baseline data in three sessions each separated by 21 days. During this phase, no change was made in the way the

subjects' care was planned by the nursing staff.

Rotter's tool to measure locus of control was completed by each subject during the first interview session. The results were correlated with the subject's six scores obtained via the power factor of the Nurse-Patient Interaction Tool (NPI Tool). The Pearson product-moment correlations showed no significant correlation between locus of control and situational perceived power/control.

The concepts of locus of control and powerlessness differ in that powerlessness is a situational perception of loss or lack of control; whereas, locus of control is a relatively unchanging perception of control. The lack of a significant correlation between the subjects' NPI power scores and the locus of control scores may indicate that there is a difference between how individuals perceive control in general versus a particular situation.

To measure the level of control and satisfaction the NPI Tool was administered at each of the six sessions. The PGC Morale Scale was administered in the first and last session only. To determine the level of involvement in care planning subjects and nurses were interviewed. The following ten questions were used to guide each of the three baseline data collection interviews to determine each subject's involvement in care:

1. How interested was the client in his/her care?
2. Are formal care conferences attended?

3. Are questions asked regarding M.D. orders?
4. Are questions about medical diagnosis asked?
5. Are the currently prescribed medications understood? Are questions about medications asked?
6. Is information to improve level of functioning sought?
7. Are concerns and ways to improve quality of care expressed?
8. Are questions regarding treatments asked?
9. Are there attempts to increase level of independence?
10. Have there been any changes in mood?

The intervention was initiated after the third data collection session. The primary nurse assigned to each subject was individually instructed by the researcher on the interactive care planning method. The instructions were to have a one to one discussion with the client about his/her plan of care. The nurse was to ask for the clients perception of problems, to ask the client for his/her opinions, and to ask for a suggested plan to resolve concerns. Care plans would then be written reflecting a collaborative approach to resolving the problems. However, after an initial attempt, the nurses expressed difficulty in completing the interventions. Consequently the administrator of the facility assumed the intervention responsibilities. She was then instructed by the researcher

using the same format. Being a registered nurse, she was familiar with nursing responsibilities and eager to implement this intervention. Over a three week period each subject met with the nurse and discussed his/her plan of care. Data collection resumed after each subject had met with the nurse and developed a plan of care. The interactive care planning method continued until the completion of data collection.

During the B or post-intervention phase of the study, three sets of data were collected twenty-one days apart using the interview process. The NPI Tool was administered during each of the three sessions to measure control and morale. The PGC Morale Scale was administered during the last session to measure morale. The post intervention involvement in care was assessed by using the same ten questions listed previously. Both nurses and clients were interviewed during each of the three post intervention sessions.

Use of the A-B design of multiple pretests, intervention, and multiple posttests was selected to establish a clear picture of trends and to determine causal effects from the independent variable rather than from extraneous variables. The actual results of this study were demonstrated in the analysis of the pre and post data from each subject (See Table 1).

The first subject was an 84 year old female. Level of

involvement in care showed no change throughout the study except in an ability to transfer self. Despite a decline in physical ability, she continued to try to assist as able. This subject expressed a need to have the staff offer assistance without being asked. She indicated that although the staff discussed her care with her; they rarely followed up on resolving her problems. She felt left out of many decisions involving financial concerns and discussed her anger about an ambulance bill for transport to the hospital. Although she felt she repeatedly told the staff that she was not injured and therefore did not want to go to the hospital. She was sent to the hospital and subsequently held responsible for the cost.

Morale for subject one, as measured by the PGC Morale Scale, remained stable with a pretest score of six and a posttest score of five. Satisfaction, measured by the NPI Tool has a possible range of 5 to 20. Pre intervention scores were 14, 13, and 14. The post intervention scores were 15, 15, and 14. Pre and post intervention scores showed very little change throughout the study.

Perceived power measured by the NPI Tool ranged between 9 and 36. Pre intervention scores were 21, 23, and 21. The post intervention scores were 19, 24, and 23. Again, these scores remained relatively stable before and after the intervention (See Tables 2 and 3).

Subject two was a 69 year old female. Level of

involvement in care showed variability in one area-- mood. This was demonstrated by the nursing data; the client spent more time in her room and seemed more depressed. Consistent throughout the six interviews was the subject's concerns that although she verbalized problems she could not resolve them. The subject expressed feelings of concern with her potential to return to her own home. She expressed anger over repeatedly canceled physical therapy sessions "due to lack of staffing." She stated that she verbalized her concerns to the nursing staff and the administration. The subject stated that the nursing staff did not follow up on issues of concern and did not act as an advocate by consulting the physician or administration. Despite the change in mood, as measured by the involvement in care questions, the level of morale, measured by the PGC Morale Scale, remained stable with a pretest score of 10 and a posttest score of 9. The satisfaction factor on the NPI Tool also remained stable throughout the study. Pre-intervention scores were 16, 15, and 15. Post-intervention scores were 17, 16, and 15.

The baseline power scores on the second subject were 25, 27, and 26. The post-intervention scores were 26, 26, and 25. Again, there was little change in the scores throughout the study (See Tables 4 and 5).

The third subject was an 82 year old female. Level of involvement in care showed no change on any of the 10 items

throughout the study. This subject stated that she only saw the nurses when she needed medication. She expressed frustration with the staff because they "did not explain things." She also stated that the nursing assistants were "rude" and did not treat her with respect.

Level of morale as measured by the PGC Morale Scale increased with a pre intervention score of 7 and a post intervention score of 13. Nevertheless, control versus powerlessness showed a decline with pre intervention scores of 19, 16, and 16 followed by post intervention scores of 15, 14, and 14.

The baseline power scores on this subject were 25, 21, and 24. The post intervention scores were 22, 27, and 24. Although there was fluctuation in these scores, there was not a trend of increasing or decreasing scores following the intervention (See Tables 6 and 7).

The fourth subject's level of involvement in care data showed many changes during the study. At the beginning of the study this 70 year old man showed no interest in attending care conferences. By the end of the study he was attending these conferences. Initially, the subject did not ask questions regarding physician orders, medical diagnosis, or medications; however, he was doing so by the end of the study. The nursing staff indicated that this subject did not attempt to improve his level of independence in activities of daily living at the beginning of the study but

was doing so by the end of the study. The subject stated that "my goals are different than the nurses' goals."

This subject's scores on the PGC Morale Scale were unchanged with a pre intervention score of 11 and a post intervention score of 11. Satisfaction scores on the NPI Tool showed no significant change between the baseline and post intervention phases. The baseline scores were 17, 14, and 15. The post intervention scores were 17, 14, and 13.

The baseline power scores on the NPI Tool on this subject were 12, 19, and 24. The post intervention scores were 21, 22, and 18. The scores showed a trend of increasing during the baseline period; after the intervention the scores dropped slightly from the highest one, increased, and then dropped again (See Tables 8 and 9).

The fifth and final subject was a 74 year old female. Level of involvement of care showed no change throughout the study. Although questions were answered during the interview sessions very little other commentary was offered during the first three sessions. Post intervention, during the fourth and fifth interview sessions, this subject expressed many complaints about late pills, outdated juices, and changes in her room arrangement. A change in placement of her privacy curtains that resulted in decreasing the amount of room available when the curtains were closed was repeatedly expressed. This change was instituted after a regulating agency survey.

Subject five's scores on the PGC Morale Scale declined with a pre intervention score of 13 and a post intervention score of 10. Satisfaction scores on the NPI Tool were 17, 16, and 15 before the intervention and 15, 14, and 15 following the intervention.

Despite increased verbalization of problems, a small increase in the power factor was found. The baseline scores were 24, 24, and 23. The post intervention scores were 27, 27, and 25 (See Tables 10 and 11).

CHAPTER V

DISCUSSION

Two hypothesis were developed for the study.

Hypothesis I: Older institutionalized adults who are able to influence the planning and implementation of their care will have less perceived feelings of powerlessness than those who do not have direct involvement in planning and implementing their care. Hypothesis II: Older institutionalized adults who are able to influence the planning and implementation of their care will have greater morale than those who do not have direct involvement in planning and implementing their care.

Subject responses on the NPI Tool showed no trend of increasing feelings of power after the intervention phase. Likewise, feelings of morale and satisfaction did not significantly increase after the intervention phase. Thus, the results of the study did not support the hypotheses.

Although differences between pre and post intervention power, morale, and satisfaction were not found, it is interesting to note that each of the subjects verbalized feelings of perceived powerlessness during the interview sessions. Statements such as "I expressed what I wanted during the care plan sessions but I never saw any results," may indicate that the staff did attempt to include the

subjects in their care; however, the subjects did not perceive that they were able to attain desired changes. In addition, all of the subjects consistently gave low scores to the NPI Tool question regarding whether the nurses ever asked for their opinion. This question consistently provoked the strongest negative response in all of the subjects. Interpretation of the study findings must consider various possibilities. Was the intervention adequately instituted? Was the written care plan really used to facilitate patient care? Can one nurse make a difference in patients' overall perceptions? Did the tools adequately measure perceived power, morale, and satisfaction? Did the length of the NPI Tool decrease its effectiveness and reliability?

Although one nurse did work with each of the subjects in developing a plan of care, the nurse was not a regular member of the staff. Therefore, the subjects may not have perceived that the nursing staff, as a whole, was interested in involving them in their care. Information given by the subjects, aside from the quantitative measures, suggest that even when a plan of care was developed with them, there was a lack of follow-through in resolving problems. Nurses were viewed as dispensers of medications and treatments rather than as a person who could aid them in developing a plan of care that could resolve their concerns. One subject stated that "The nurse just gives me the pills that the doctor

orders. I hardly ever see her otherwise." Nurses were not viewed as patient advocates and subjects frequently complained of a lack of results when they did express problems to the nurse.

Likewise, nurses did not view themselves as patient advocates who could assist clients to exert control over their lives. They indicated that it was not necessary to ask the patient for his/her opinion because "they always tell you anyway." The results of this study suggest that nurses may need assistance to develop the skill of interactive, client autonomous care planning.

Despite expressions of powerlessness and lack of change in pre/post scores on the PGC Morale Scale, subjects verbalized a fair amount of overall satisfaction. This could be explained by the subjects' utilization of coping mechanisms that allowed them to feel satisfied with their circumstances. For example, one subject reported pretending that she lived on a cruise ship. Although she was able to separate reality from fiction, this coping mechanism may enable her to live a more satisfying life.

Although the subjects were able to respond appropriately to the questions on the research tools, they verbalized a desire to discuss the issues at greater length. The researcher noted that these elderly subjects were unfamiliar with responding to written questions and that they had some difficulty choosing between alternative

responses.

It should also be recognized that the subjects in the study may have experienced the "halo effect." The scores on each of the tools may be inflated due to the subjects increased feelings of power and satisfaction resulting only from the attention they received because they were involved in this study.

Implications For Further Research

Future studies must address the issue of preparing nurses to work proficiently with clients to develop interactive plans of care and to ensure that nursing staff are consistent in their approach to the client. A commitment to interactive care planning by both the nursing staff and the administration should support future research efforts.

In addition, changes in study design should be considered. A larger sample could be utilized to increase internal and external validity. Increasing control over the intervention must be accomplished to ensure that effects are from the independent variable rather than extraneous variables.

The elderly subjects in this study indicated that they desired to share more information than the quantitative tools could capture. Because the assumptions of this study are now questioned, future researchers may consider use of a qualitative design to gain more information from which to

proceed to a quantitative design. Use of triangulation of methods may also be utilized.

In summary, previous studies and comments from subjects in this study indicate a need for patients to have some control over their lives. Although this beginning work did not find support for the stated hypotheses, the study was rich in discovery. Future studies are needed to better understand the feelings of powerlessness in the institutionalized elderly.

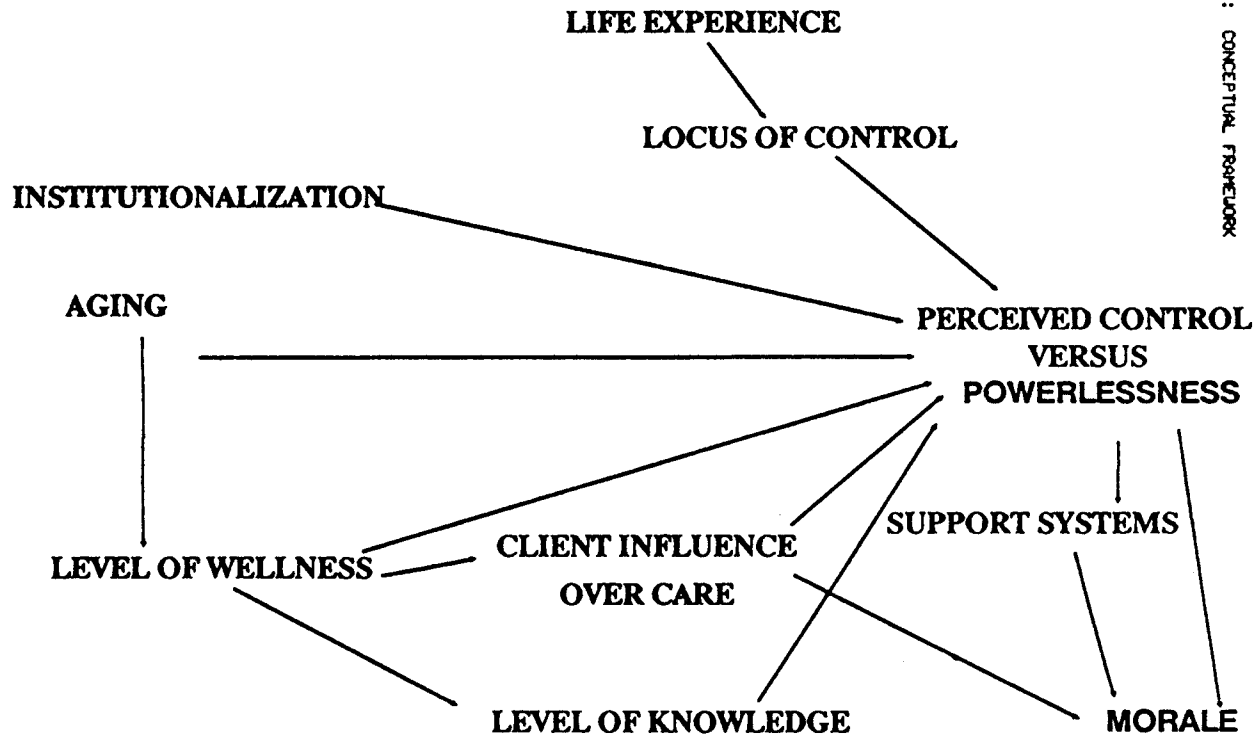


FIGURE 1: CONCEPTUAL FRAMEWORK

Appendix B

Tool 1:
NURSE-PATIENT INTERACTION TOOL

Please answer the following questions. Circle the appropriate number for each question.

- 1 = not at all
2 = very little
3 = a fair amount
4 = a great deal

1. How much input did you feel that you had into the decision about your plan of care? 1 2 3 4
2. Do you feel you had control over the plan of care decided on? 1 2 3 4
3. Are you likely to follow the suggested treatment? 1 2 3 4
4. Do you feel you were involved in decisions made during the care planning sessions? 1 2 3 4
5. Do you feel you will be able to follow the suggested plan of care? 1 2 3 4
6. Do you feel the nurse understood your problems? 1 2 3 4
7. Did you feel that you were in control of your plan of care? 1 2 3 4
8. Do you feel you receive good care? 1 2 3 4
9. Do you feel the nurse was interested in having you involved in decision making? 1 2 3 4
10. How much did you contribute to the final decisions about your care? 1 2 3 4
11. Did the nurse allow you to speak up? 1 2 3 4
12. How often do you feel the nurse asked for your opinion? 1 2 3 4
13. How comfortable are you with your plan of care? 1 2 3 4

14. Were your ideas included in your
plan of care? 1 2 3 4

Appendix C

Tool 2:
PGC Morale Scale

Item	High Morale	Low Morale
Factor 1 - Agitation		
4. Do little things bother you more this year?	No	Yes
7. Do you sometimes worry so much that you can't sleep?	No	Yes
12. Are you afraid of a lot of things?	No	Yes
13. Do you get mad more than you used to?	No	Yes
16. Do you take things hard?	No	Yes
17. Do you get upset easily?	No	Yes
Factor 2 - Attitude Toward Own Aging		
1. Do things keep getting worse as you get older?	No	Yes
2. Do you have as much pep as you had last year?	Yes	No
6. Do you feel that as you get older you are less useful?	No	Yes
8. As you get older, are things _____ than you thought?	Better	Worse or Same
10. Are you as happy now as you were when you were younger?	Yes	No
Factor 3 - Lonely Dissatisfaction		
3. How much do you feel lonely?	Not Much	A Lot
5. Do you see enough of your friends and relatives?	Yes	No
9. Do you sometimes feel that life isn't worth living?	No	Yes

- | | | | |
|-----|---|-----------|---------------|
| 11. | Do you have a lot to be sad about? | No | Yes |
| 14. | Is life hard much of the time? | No | Yes |
| 15. | How satisfied are you with your life today? | Satisfied | Not Satisfied |

Appendix D

Tool 3:

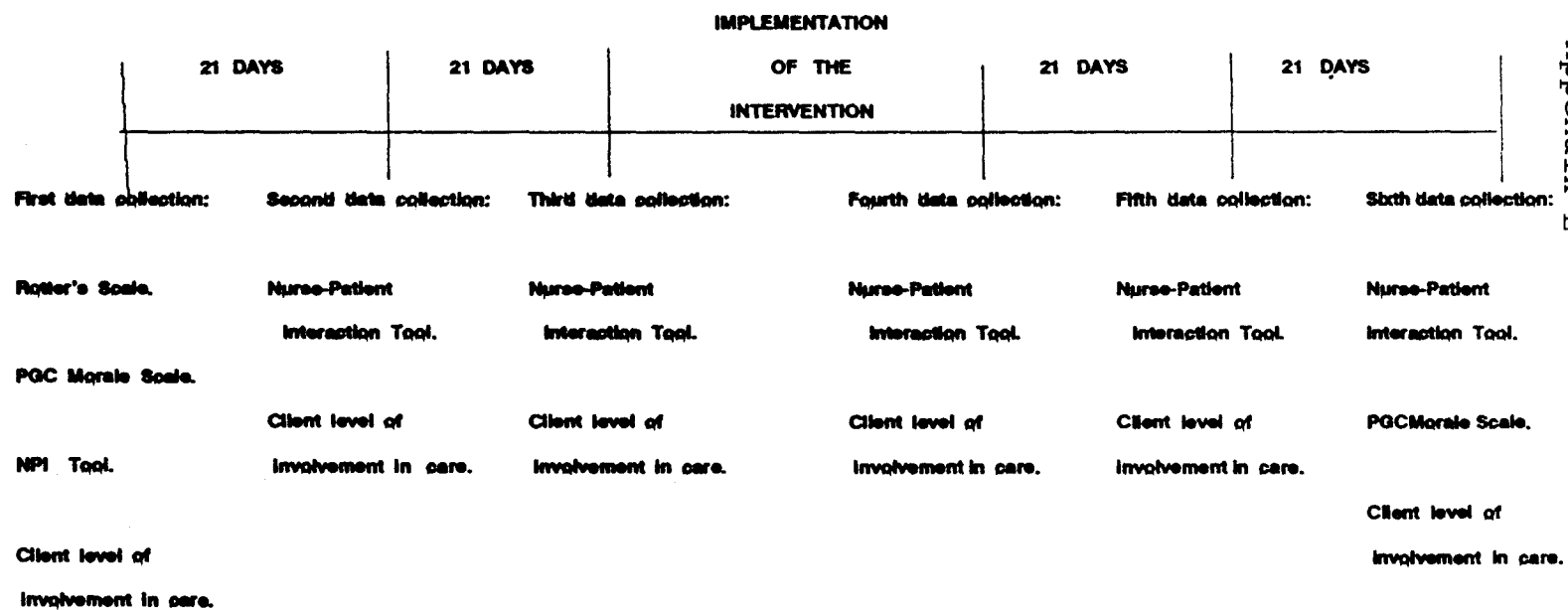
ROTTER'S INTERNAL VS. EXTERNAL CONTROL SCALE

- 1.a. Children get into trouble because their parents punish them too much.
- b. The trouble with most children nowadays is that their parents are too easy with them.
- 2.a. Many of the unhappy things in people's lives are partly due to bad luck.
- b. People's misfortunes result from the mistakes they make.
- 3.a. One of the major reasons why we have wars is because people don't take enough interest in politics.
- b. There will always be wars, no matter how hard people try to prevent them.
- 4.a. In the long run people get the respect they deserve in this world.
- b. Unfortunately, an individual's worth often passes unrecognized no matter how hard he tries.
- 5.a. The idea that teachers are unfair to students is nonsense.
- b. Most students don't realize the extent to which their grades are influenced by accidental happenings.
- 6.a. Without the right breaks one cannot be an effective leader.
- b. Capable people who fail to become leaders have not taken advantage of their opportunities.
- 7.a. No matter how hard you try some people just don't like you.
- b. People who can't get others to like them don't understand how to get along with others.
- 8.a. Heredity plays the major role in determining one's personality.
- b. It is one's experiences in life which determine what one is like.
- 9.a. I have often found that what is going to happen will happen.
- b. Trusting to fate has never turned out as well for me as making a decision to take a definite course of action.

- 10.a. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.
b. Many times exam questions tend to be so unrelated to course work that studying is really useless.
- 11.a. Becoming a success is a matter of hard work, luck has little or nothing to do with it.
b. Getting a good job depends mainly on being in the right place at the right time.
- 12.a. The average citizen can have an influence in government decisions.
b. This world is run by the few people in power, and there is not much the little guy can do about it.
- 13.a. When I make plans, I am almost certain that I can make them work.
b. It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.
- 14.a. There are certain people who are just no good.
b. There is some good in everybody.
- 15.a. In my case getting what I want has little or nothing to do with luck.
b. Many times we might just as well decide what to do by flipping a coin.
- 16.a. Who gets to be the boss often depends on who was lucky enough to be in the right place first.
b. Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.
- 17.a. As far as world affairs are concerned, most of us are the victims of forces we can neither understand, not control.
b. By taking an active part in political and social affairs the people can control world events.
- 18.a. Most people don't realize the extent to which their lives are controlled by accidental happenings.
b. There really is no such thing as "luck."
- 19.a. One should always be willing to admit mistakes.
b. It is usually best to cover up one's mistakes.
- 20.a. It is hard to know whether or not a person really likes you.
b. How many friends you have depends on how nice a person you are.

- 21.a. In the long run the bad things that happen to us are balanced by the good ones.
- b. Most misfortunes are the result of lack of ability, ignorance, laziness, or all three.
- 22.a. With enough effort we can wipe out political corruption.
- b. It is difficult for people to have much control over the things politicians do in office.
- 23.a. Sometimes I can't understand how teachers arrive at the grades they give.
- b. There is a direct connection between how hard I study and the grades I get.
- 24.a. A good leader expects people to decide for themselves what they should do.
- b. A good leader makes it clear to everybody what their jobs are.
- 25.a. Many times I feel that I have little influence over the things that happen to me.
- b. It is impossible for me to believe that chance or luck plays an important role in my life.
- 26.a. People are lonely because they don't try to be friendly.
- b. There's not much use in trying too hard to please people, if they like you, they like you.
- 27.a. There is too much emphasis on athletics in high school.
- b. Team sports are an excellent way to build character.
- 28.a. What happens to me is my own doing.
- b. Sometimes I feel that I don't have enough control over the direction my life is taking.
- 29.a. Most of the time I can't understand why politicians behave the way they do.
- b. In the long run the people are responsible for bad government on a national as well as on a local level.

Figure 2: PROCESS AND PROCEDURE: A TIME LINE



Appendix E

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Woods, N., Catanzaro, M. (1988). Nursing Research: Theory and Practice. C.V. Mosby Company; St. Louis.

Table 1

Scores for power component of NPI Tool
 Data:1 Data:2 Data:3--Data:4 Data:5 Data:6
 PRE INTERVENTION----POST INTERVENTION

Subject 1=	21	23	21	19	24	23
Subject 2=	25	27	26	26	26	25
Subject 3=	25	21	24	22	27	24
Subject 4=	12	19	24	21	22	18
Subject 5=	24	24	23	23	27	25

Scores for satisfaction component of NPI Tool
 Data:1 Data:2 Data:3--Data:4 Data:5 Data:6
 PRE INTERVENTION----POST INTERVENTION

Subject 1=	14	13	14	15	15	14
Subject 2=	16	15	15	17	16	15
Subject 3=	19	16	16	15	14	14
Subject 4=	17	14	15	17	14	13
Subject 5=	17	16	15	15	14	15

PGC MORALE SCALE
 PRE INTERVENTION----POST INTERVENTION

Subject 1=	6	5
Subject 2=	10	9
Subject 3=	7	13
Subject 4=	11	11
Subject 5=	13	10

Table 2

Data on Subject #1 Nurse-Patient Interaction Tool

	7/11/92	7/31/92	8/21/92	10/5/92	10/26/92	11/16/92
	Data:1	Data:2	Data:3	Data:4	Data:5	Data:6
#1/P	3	3	3	2	3	3
#2/P	2	3	3	2	3	3
#3/S	3	3	3	3	3	3
#4/P	3	3	2	2	3	3
#5/S	2	3	3	3	3	3
#6/S	3	2	2	3	3	3
#7/P	2	3	2	2	3	3
#8/S	3	3	3	3	3	3
#9/P	2	2	2	3	3	3
#10/P	3	2	2	2	3	3
#11/P	3	3	3	3	3	2
#12/P	1	2	2	1	1	1
#13/S	3	2	3	3	3	2
#14/P	2	2	2	2	2	2

Range of possible power scores= 9-36

Power	21	23	21	19	24	23
Scores						

Range of possible satisfaction scores= 5-20

Satisfaction	14	13	14	15	15	14
Scores						

PGC Morale Scale

Pre Intervention	Post Intervention
6	5

Table 3

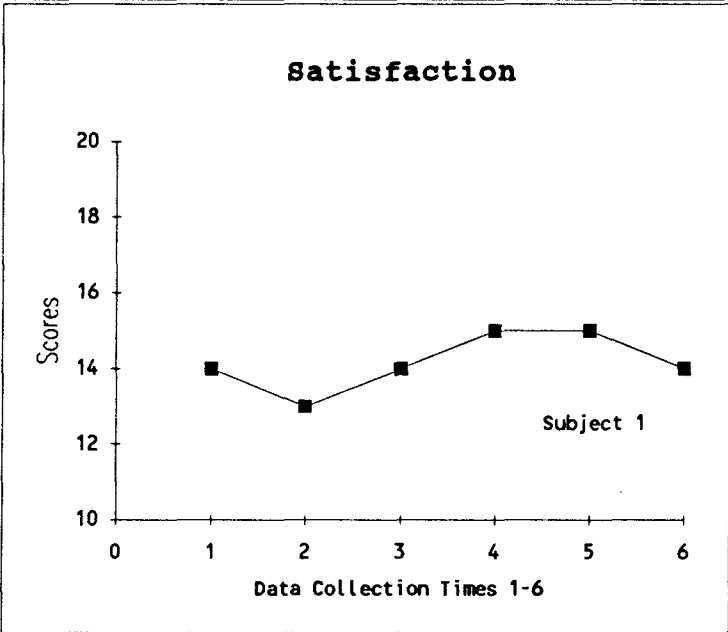
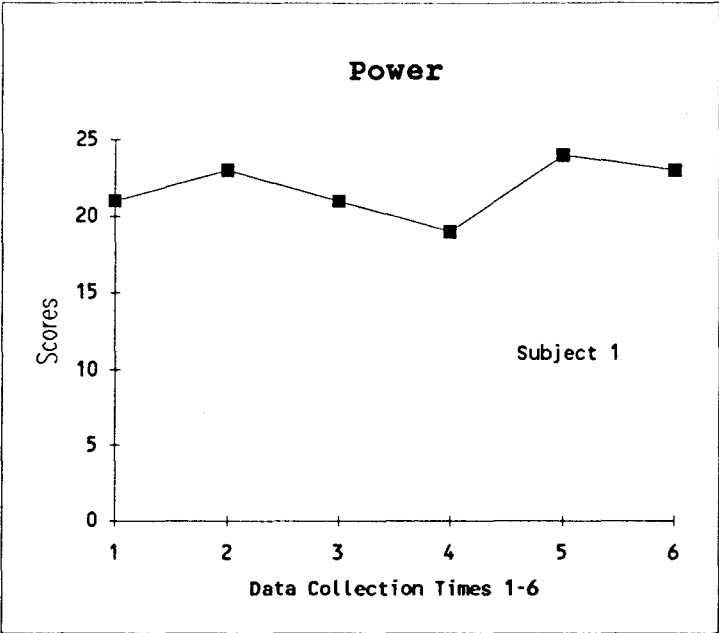


Table 4

Data on Subject #2 Nurse-Patient Interaction Tool
 7/11/92 7/31/92 8/21/92 10/5/92 10/26/92 11/16/92
 Data:1 Data:2 Data:3 Data:4 Data:5 Data:6

#1/P	2	3	3	3	3	3
#2/P	3	3	3	3	3	3
#3/S	4	3	3	4	4	3
#4/P	1	3	3	4	3	3
#5/S	3	3	3	4	3	3
#6/S	3	3	3	3	3	3
#7/P	3	3	3	3	3	3
#8/S	3	3	3	3	3	3
#9/P	3	3	3	3	3	3
#10/P	3	3	3	3	3	3
#11/P	4	3	3	3	3	3
#12/P	3	3	2	1	2	1
#13/S	3	3	3	3	3	3
#14/P	3	3	3	3	3	3

Range of possible power scores= 9-36

Power Scores	25	27	26	26	26	25
--------------	----	----	----	----	----	----

Range of possible satisfaction scores= 5-20

Satisfaction Scores	16	15	15	17	16	15
---------------------	----	----	----	----	----	----

PGC Morale Scale	
Pre Intervention	Post Intervention
10	9

Table 5

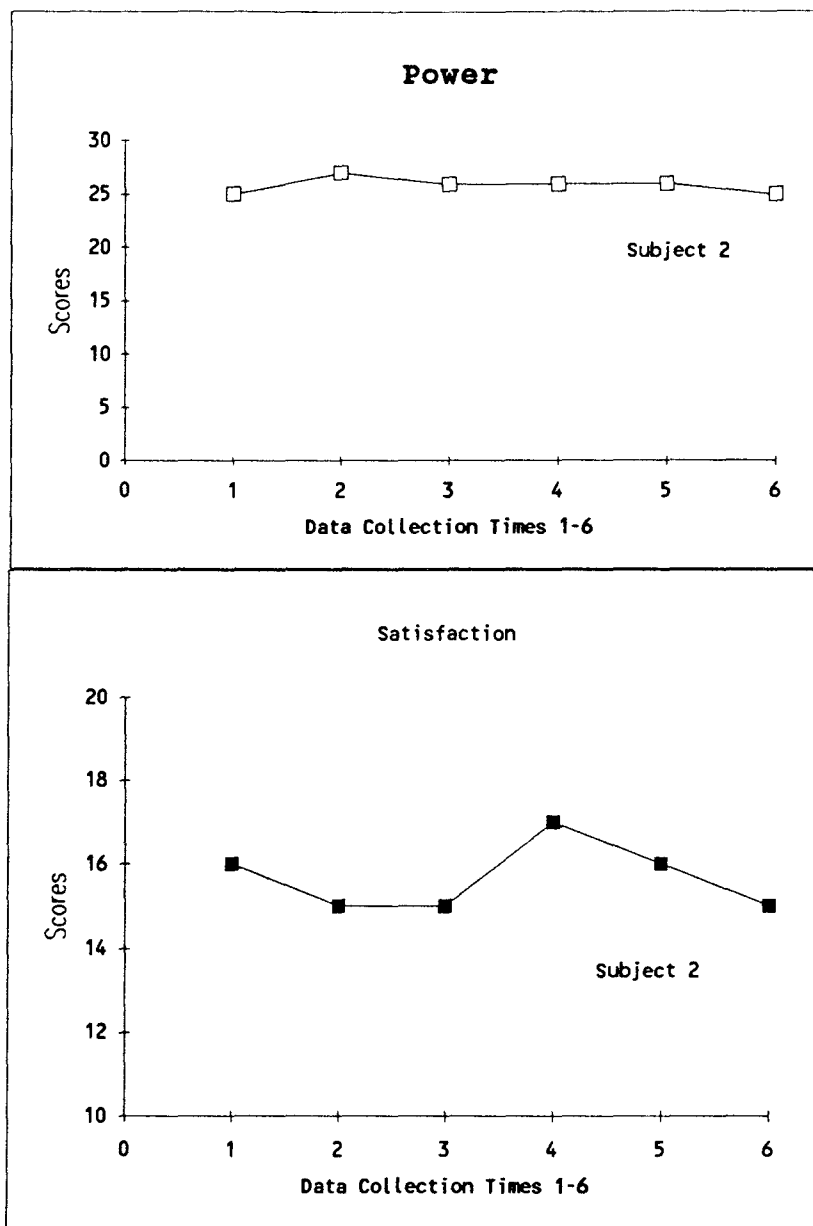


Table 6

Data on Subject #3 Nurse-Patient Interaction Tool
 7/11/92 7/31/92 8/21/92 10/5/92 10/26/92 11/16/92
 Data:1 Data:2 Data:3 Data:4 Data:5 Data:6

#1/P	3	3	3	3	4	3
#2/P	4	3	3	3	3	3
#3/S	4	3	3	3	3	3
#4/P	1	2	2	2	4	3
#5/S	4	3	3	3	3	3
#6/S	4	3	3	3	2	2
#7/P	3	2	3	2	3	3
#8/S	4	3	4	3	3	3
#9/P	3	3	3	3	2	2
#10/P	3	3	3	3	3	3
#11/P	3	2	3	3	3	3
#12/P	1	1	1	1	2	1
#13/S	3	4	3	3	3	3
#14/P	4	2	3	2	3	3

Range of possible power scores= 9-36

Power Scores	25	21	24	22	27	24
--------------	----	----	----	----	----	----

Range of possible satisfaction scores= 5-20

Satisfaction Scores	19	16	16	15	14	14
---------------------	----	----	----	----	----	----

	PGC Morale Scale	
	Pre Intervention	Post Intervention
	7	13

Table 7

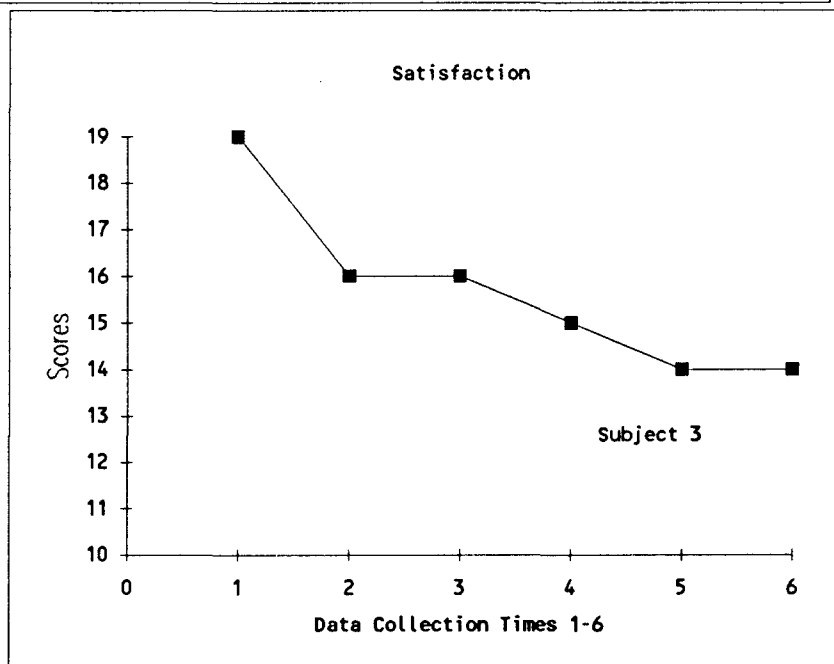
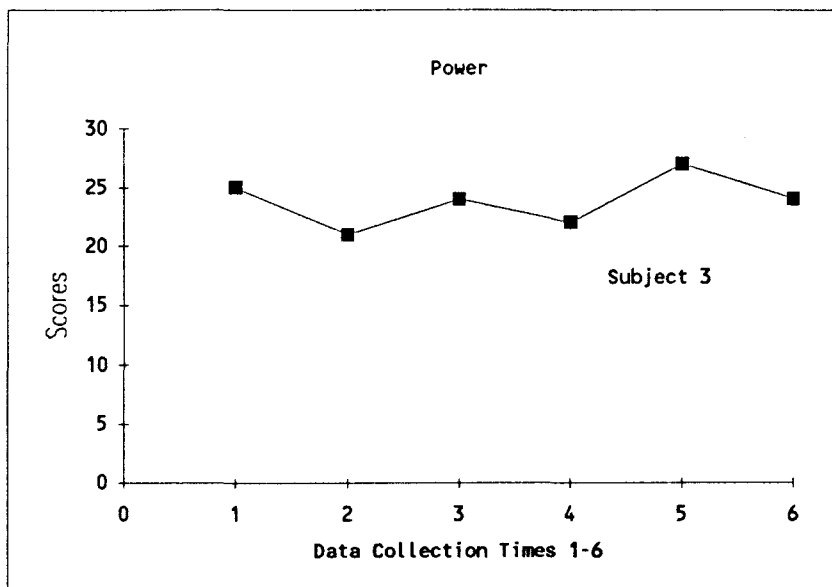


Table 8

Data on Subject #4 Nurse-Patient Interaction Tool

7/11/92 7/31/92 8/21/92 10/5/92 10/26/92 11/16/92

Data:1 Data:2 Data:3 Data:4 Data:5 Data:6

#1/P	1	2	3	3	2	2
#2/P	1	1	3	3	2	2
#3/S	3	3	3	4	3	3
#4/P	1	3	3	3	4	1
#5/S	4	3	3	3	4	3
#6/S	3	2	3	4	2	2
#7/P	1	3	3	2	2	2
#8/S	4	3	3	3	3	3
#9/P	1	1	3	2	3	3
#10/P	1	3	3	2	4	3
#11/P	3	3	3	3	3	3
#12/P	2	1	1	1	1	1
#13/S	3	3	3	3	2	2
#14/P	1	2	2	2	1	1

Range of possible power scores= 9-36

Power Scores	12	19	24	21	22	18
--------------	----	----	----	----	----	----

Range of possible satisfaction scores= 5-20

Satisfaction Scores	17	14	15	17	14	13
---------------------	----	----	----	----	----	----

PGC Morale Scale

Pre Intervention	Post Intervention
11	11

Table 9

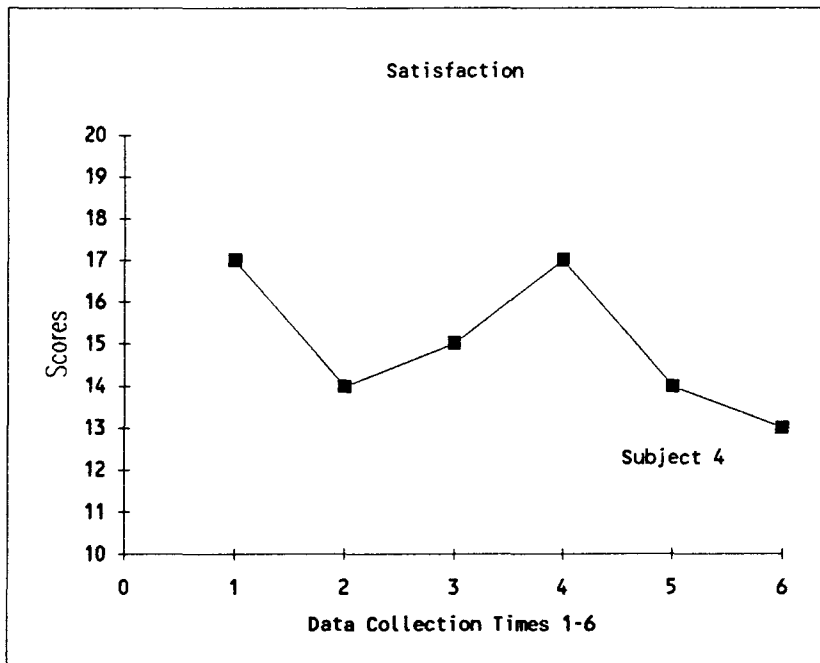
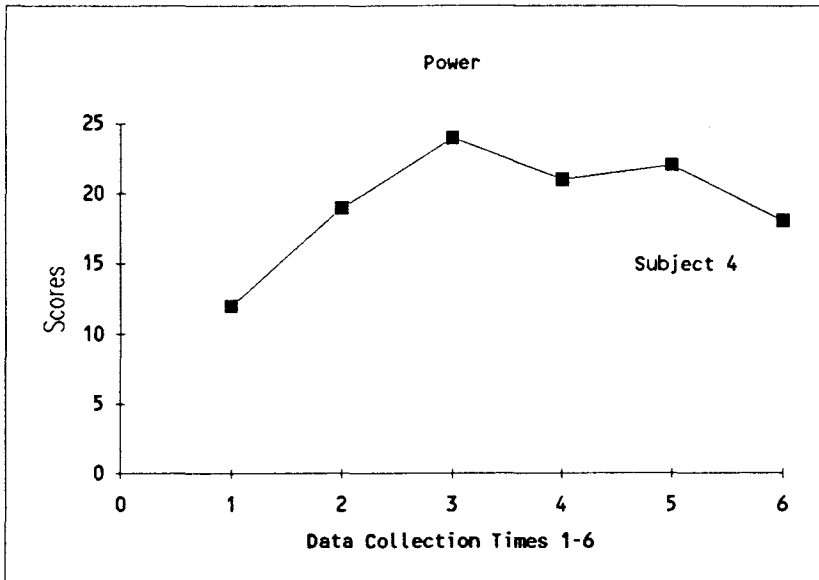


Table 10

Data on Subject #5 Nurse-Patient Interaction Tool
 7/11/92 7/31/92 8/21/92 10/5/92 10/26/92 11/16/92
 Data:1 Data:2 Data:3 Data:4 Data:5 Data:6

#1/P	3	3	2	3	3	3
#2/P	3	3	3	3	3	3
#3/S	3	3	3	3	3	3
#4/P	1	3	3	3	3	3
#5/S	3	3	3	3	3	3
#6/S	4	3	2	3	2	3
#7/P	2	3	3	3	3	3
#8/S	3	4	4	3	3	3
#9/P	3	3	2	3	3	3
#10/P	4	2	3	3	3	3
#11/P	4	3	3	3	3	3
#12/P	2	1	1	3	3	1
#13/S	4	3	3	3	3	3
#14/P	2	3	3	3	3	3

Range of possible power scores= 9-36

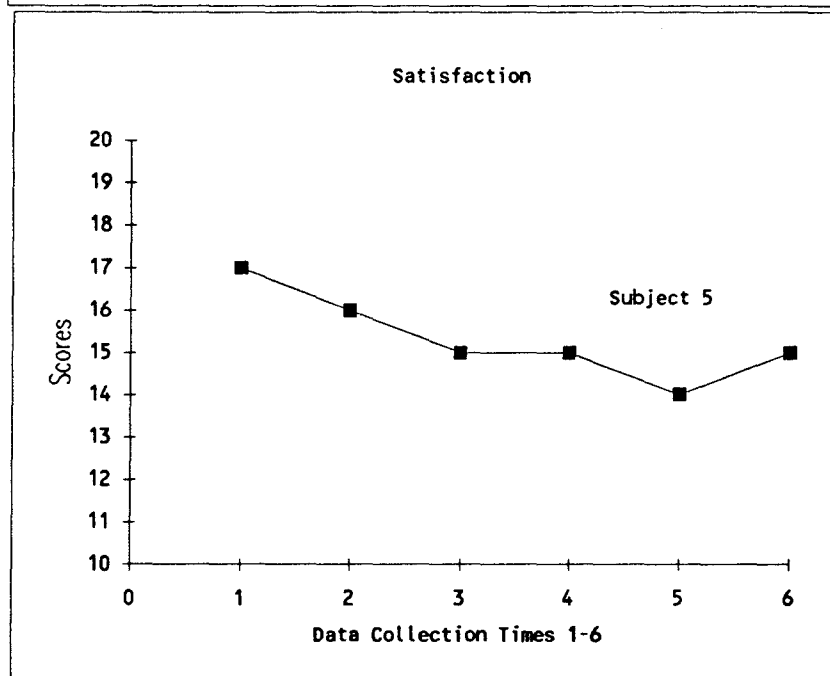
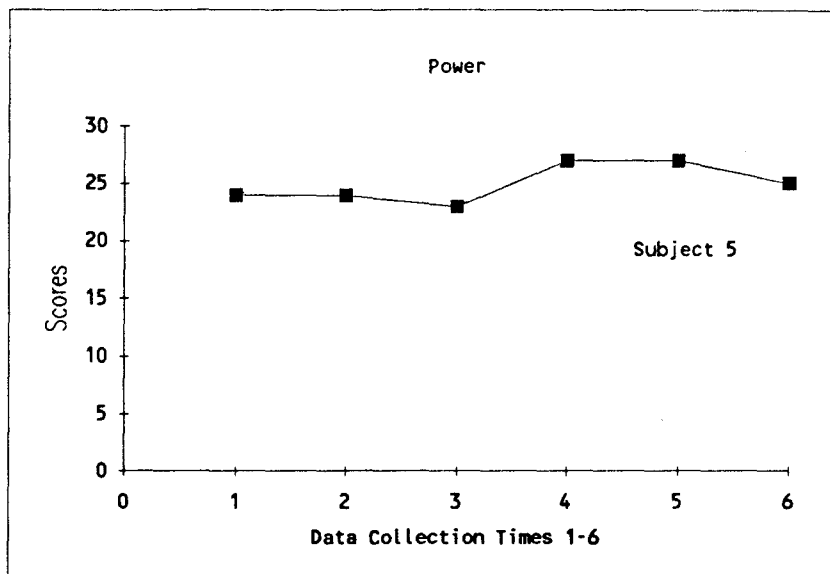
Power	24	24	23	27	27	25
Scores						

Range of possible satisfaction scores= 5-20

Satisfaction	17	16	15	15	14	15
Scores						

	PGC Morale Scale	
Pre Intervention		Post Intervention
	13	10

Table 11



The thesis submitted by Janis Ormond has been read and approved by the following committee:

Dr. Jewell Chambers
Assistant Professor, School of Nursing

Dr. Eileen Dvorak
Professor, School of Nursing

Dr. Karen Egenes
Assistant Professor, School of Nursing

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The thesis is, therefore, accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

April 19, 1993

A handwritten signature in cursive script that reads "Jewell Chambers Ph.D." The signature is written in dark ink and is positioned to the right of the date.